

MAY 25 1934

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

14033

1. PLACE OF DEATH

County St. Francois

Registration District No. 773

File No. _____

Township St. Francois

Primary Registration District No. 6018A

Registered No. 74

Near City Farmington, Mo. (No. _____)

St. _____ Ward _____

2. FULL NAME Carroll Woodward

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 29, 1934

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

22. I HEREBY CERTIFY, That I, attended deceased from Oct 13, 1929 to April 29, 1934

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-10-76

I last saw him alive on April 29, 1934 Death is said

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 58 1 19

to have occurred on the date stated above, at 10:30 pm.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Architect
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____
11. Total time (years) spends in this occupation _____

Paresis
chronic myocarditis & aortic
Date of onset _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mexico Mo.

FATHER 13. NAME Dan Woodward

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Paris Mo.

MOTHER 15. MAIDEN NAME Susan Rodden

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Hospital Records Farmington, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mexico Mo. DATE ? 19. _____

19. UNDERTAKER (ADDRESS) Mc Peterson Mexico Mo.

20. FILED Apr 30, 1934 B. J. Robinson Registrar.

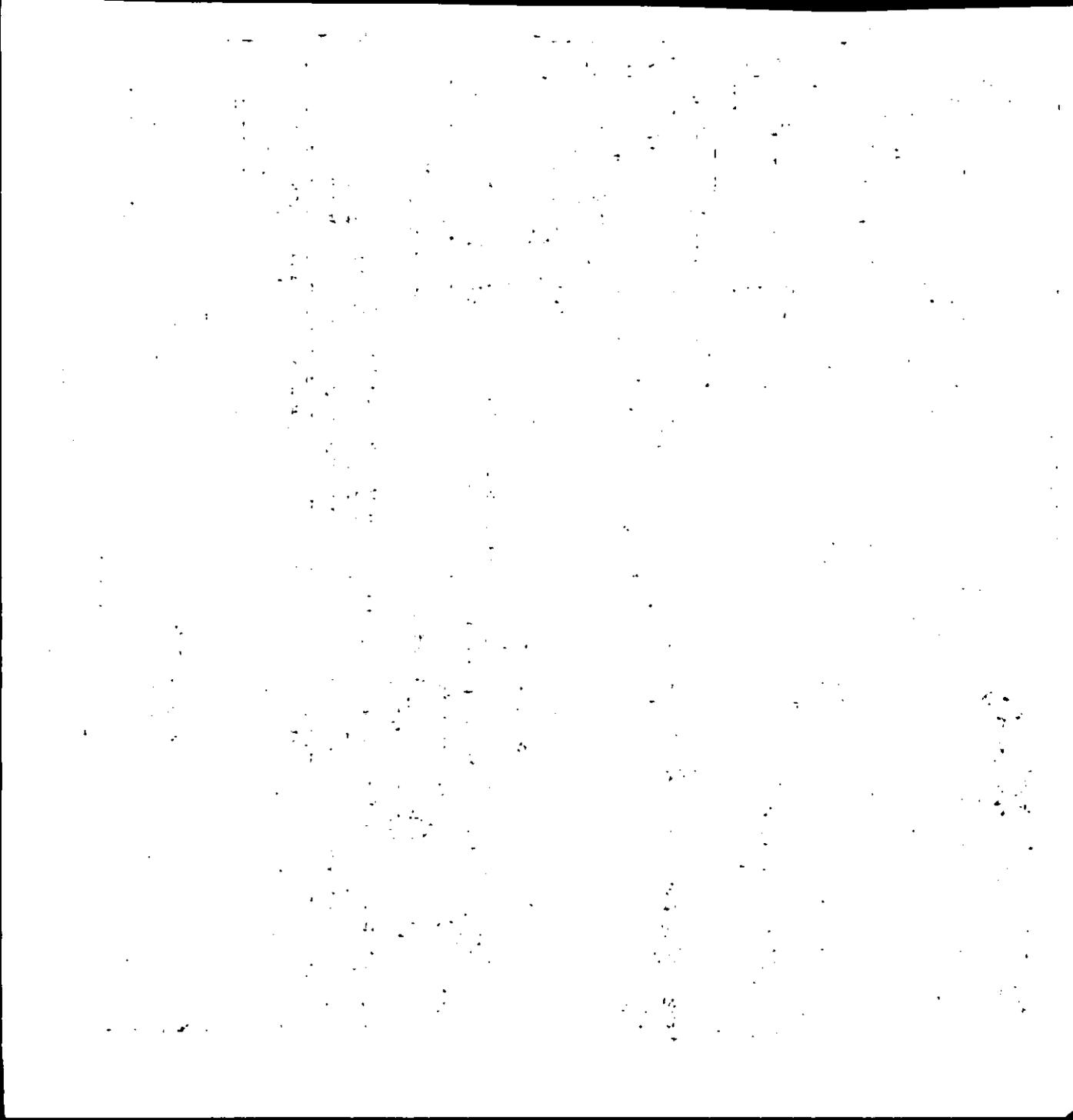
Name of operation _____ Date of _____
What test confirmed diagnosis? clinical & Path. _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) P. S. Tate M. D.
(Address) Hosp. #4 Farmington Mo.



Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Carroll Woodward
Who died at _____ on April 29 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex M Color or race W Single, married, widowed or divorced: _____
Date of birth _____ Age: Years 58 Months 1 Days 19

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) _____
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____
Principal cause of death: Paralysis (Syphilitic)
General Paralysis of Insane

Other contributory causes of importance: Chronic myocarditis & aortitis
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician _____
Address of physician _____
Signature of Registrar E. J. Robinson

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 773

Very truly yours,
E. T. McGaugh M.D.
S.A.

Primary Reg. Dist. No. 6018a

Special Agent.

S-14033